Self-Report Form

Name:		
Home Phone:	Work Phone:	Cell Phone:
Marital Status: Single Married Widowed Divorced Separated Partnered Minor		
Employment Status: Full-time Part-time Retired Non-employed Homemaker		
If Student: Full-time Part-time		

Why are you seeking treatment? _____

_____

_____

Are you now or have you been treated by a psychiatrist or therapist? Yes No
If yes, please list when, where, by whom, and your diagnosis: _____

_____

_____

Have you been hospitalized for psychiatric or chemical dependency problems? Yes No
If yes, please list when, where, by whom, and your diagnosis: _____

_____

_____

If applicable, please list any traumatic or extremely upsetting events that might have occurred to you: _____

Are you experiencing?

Depression:	Yes	No
Loss of interest in activities:	Yes	No
Loss or increase in appetite:	Yes	No
Significant weight loss or gain:	Yes	No
Increase or decrease in sleep:	Yes	No
Increase or decrease in energy level:	Yes	No

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Feelings of worthlessness or guilt:	Yes	No
Problems in concentration or decision-making:	Yes	No
Thoughts about death, suicide, or self-harm:	Yes	No
Anxiety:	Yes	No
Panic or anxiety attacks:	Yes	No
Addictive behaviors:	Yes	No
Concerns about body image:	Yes	No
Persistent unpleasant thoughts:	Yes	No
Times when you engage in repetitive behaviors:	Yes	No
Worries about physical health, finances, other:	Yes	No

Have you ever experienced any of the following?

Perieods of at least four days when you were so happy or excited that you got into trouble or others became worried about you:	Yes	No
Periods of at least four days of irritablility or temper problems:	Yes	No
Racing throughs or an inability to keep up with your thoughts:	Yes	No
Throughts that others are out to get you:	Yes	No
Hallucinations:	Yes	No
Memory Problems:	Yes	No

How many times during the month do you consume alcohol? How much?

Do you currently use or have you recently used illegal drugs? Yes No
If yes, please list: _____

Is there any family history of psychiatric illness or chemical dependency such as:

Depression	Yes	No	ADHD	Yes	No
Bipolar Disorder	Yes	No	Anxiety Disorders	Yes	No
Schizophrenia	Yes	No	Alcoholism	Yes	No
OCD	Yes	No	Drug Addiction	Yes	No
Learning Problems	Yes	No	Suicide attempts	Yes	No

Do you consider yourself spiritual or religious? Yes No
If yes, how do you practice or express you spiritualality?

Please list all current psychiatric medications:

Medication	Dosage	How long	Reason	Doctor

Please list all psychiatric medications used previously: